

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM
PO Box 299 Trenton, New Jersey 08625-0299

RESOLUTION

A RESOLUTION to terminate participation under the New Jersey State Health Benefits Program Act of the State of New Jersey for SHBP Dental Plan coverage only.

BE IT RESOLVED:

1. The _____,
Name of Employer
hereby resolves to terminate its participation in the SHBP Employee Dental Plans thereby canceling dental coverage provided by the New Jersey State Health Benefits Program (N.J.S.A. 52:14-17.25 et seq.) for all its active employees.
2. We shall notify all active employees of the date of their termination of coverage under the program.
3. We understand that all COBRA participants will be notified by the Division of Pensions and Benefits and advised to contact our office concerning a possible alternative dental program.
4. We understand that this resolution shall take effect the first of the month following a 60-day period beginning with the receipt of the resolution by the State Health Benefits Commission.

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the

Corporate Name of Employer
on the _____ day of _____, 20____.

Signature

Official Title

Street Address

City State ZIP Code

Area Code Telephone

Please complete the reverse side of this form.

PLEASE COMPLETE AND COMPLY WITH THE FOLLOWING:

A. Employer New Jersey State Health Benefits Program Identification Number

B. New Dental Plan Carrier

C. Reason for termination of the SHBP Employee Dental Plans

D. In accordance with N.J.S.A. 18A:16-21 and 40A:10-25, you must file a copy of your new contract with the State Health Benefits Commission. Please submit a copy of the new contract with this completed resolution.